LAKESHORE FERNBROOK

FORM APPROVED

UUL-27-2015 07:58 LAKESHORE FERNBI CENTERS FOR MEDICARE & MEDICAID SERVICES P.002 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A BUILDING _ (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 44A114 B. WING LAKESHORE HEARTLAND STREET ADDRESS, CITY, STATE, ZIP CODE 06/10/2015 \$025 FERNBROOK LANE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES NASHVILLE, TN 37214 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ΙD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 178 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE SS≃D : F 176 1. Resident #57's medications were 07/30/15 removed from bedside on 06/08/15. On An individual resident may self-administer drugs if the interdisciplinary team, as defined by 06/09/15, the resident was reassessed §483.20(d)(2)(ii), has determined that this for self administration of medications and found to be unsafe to self practice is safe. administer medications. The physician was notified and medication orders This REQUIREMENT is not met as evidenced were clarified. The care plan was updated on 06/09/15. Based on review of facility policy, medical record 2. By 06/18/15, Nursing Administration review, observation and interview the facility failed completed a 100% reassessment of all to monitor the self-administration of medication residents who self administer for 1 resident (#57) of 25 residents reviewed. medications with no issues identified. On 06/12/15, an order was added to all The findings included: residents who self administer medications for the charge nurse to Review of the facility policy Self-Administration "Check all medications kept at bedside revised August 2006, revealed "...Selffor safety and compliance" cach shift. Administered medications must be stored in a Nurses were alerted to this via the safe and secure place, which is not accessible to message board on the electronic health other residents...Staff shall identify...medications record system from 06/12/15 through found at the bedside that are not authorized for 07/01/15 bedside storage..." The Director of Nurses, or designee, will review the Medication Medical record review revealed Resident #57 was Administration Records each month admitted to the facility on 4/30/12, with diagnoses during recapitulation to ensure including Scoliosis, Anxiety, Depression, and compliance with this monitoring. Hypertension. Issues will go to the Quality Assurance Committee for resolution. Medical record review of the annual Minimum

Data Set (MDS) dated 3/21/15, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 (indicating the resident was cognitively intact for daily decision making).

Medical record review of the Care Plan dated 4/3/15, revealed "...Problem onset 4/3/15...I use eye drops...wash your hands before administering ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 lys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

French

UUL-27-2015 07:59 LAKESHORE FERNBROOK DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

STATEME	NT OF DEFICIENCIES	S WEDICAID SERVICES			EADM	' VV(44140)		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	OWR NO	FORM APPROVE OMB NO. 0938-039 (X3) DATE SURVEY		
		44444	A BUILDING	·	CON	E SURVEY		
NAME OF	PROVIDER OR SUPPLIER	44A114	B. WING		İ			
LAKES	HORE HEARTLAND		\$	TREET ADDRESS, CITY, STATE, ZIP CODE		10/2015		
(X4) ID			3	025 FERNBROOK LANE ASHVILLE, TN 37214				
PRÉFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFY OF THE PROPERTY OF	ID T	PROVIDER'S DI AN OR DE				
	- TORTORI	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRI		(X5) COMPLETION DATE		
F 176	Continued From page	ne 1	1	DEFICIENCY)				
	my drops"	, , , , , , , , , , , , , , , , , , ,	F 176		1	,		
	Medical record revie	M of the Develop						
	Recapitulation Order	rs dated 6/2015 revealed no						
[(lubricant) Eve Drope	su atton of the Systane	!		ļ	ł		
	(lubricant) Eye Drops	i.			1	1		
	Medical record review	v of a Physician's Telephone				- 1		
	Order dated 6/4/15, r Systane Eye Drops	evealed "D/C (discontinue)			1]		
- 1	2 · · · · · · · · · · · · · · · · · · ·	·						
	Observation on 6/8/18 resident's room, revea	5, at 3:05 PM, in the aled 2 bottles of Systane			1	1		
	eye drops and 1 bottle	e of Refresh Eye Drops on			1	1		
ł	- 45/40	ranie,				- 1		
	Oterview with Residen	it #57 on 6/8/15, at 3:11	[-			
₽	ractical Nurse (LDA)	rom, with Licensed				- 1		
i tv	Vice on 6/7/15	eo the Systane eye drops	.		ĺ			
<u>u</u>	nsure of the last time	red the Systane eye drops nee on 6/8/15, and was she had used the Refresh				- 1		
- 1	•	1	İ		1			
in	terview with LPN #1 o	n 6/8/15, at 3:15 PM, at						
dn	ODS Were not stored -	whom commed the eve				- 1		
Dn	ODS had been disas-	paled the Systane Eye				[
ha	d been no order for the	mued on 6/4/15, there						
eve	Grops from the had-	to remove the Systane	1			}		
and	had failed to obtain	an order for the Refresh			1)		
	·		}					
Inte	erview with the Directo	or of Nurses (DON), on			1			
CON	firmed the facility had	e DON's Office,	}					
2587/02-	99) Provious 16	to remove the	1		1	1		

UUL-27-2015 07:59 DEPARTMENT OF HEALTH AND HUMAN SERVICES LAKESHORE FERNBROOK

P.004 PRINTED: 06/24/2015 FORM APPROVED

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDERSUPPLIERCLIA	—		FOR	ED: 06/2 RM APP
	- volucionon	IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CONSTRUCTION	OMB N	<u>IO. 093</u>
			A BUILD	ING	(X3) D	ATE SUR OMPLETE
NAME OF	PROVIDER OR SUPPLIER	44A114	B. WING		"	
				STREET ADDRESS COM	0	6/10/20
	ORE HEARTLAND		1	STREET ADDRESS, CITY, STATE, ZIP CO 3026 FERNBROOK LANE	DE	
(2(4) 10	SUMMADVICTA		- [NASHVILLE, TN 37214		
PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID			
	MEGULATURY OR LS	MLST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX			COM
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F 176	-a	e 2				
- 1	Systane ave drope &	A-4	F 17		ector	07/
			Í	conducted an audit of prefer residents who cat in the dinir the 3 rd and 4 rd Section 10 and 10 an		'''
[Refresh eye drops, a	nd the facility failed to follow		the 3 rd and 4 th floors regarding a dining table on anti-	ng areas on	1
F 252	the policy for Self-Adi	ministration of Drugs			g cating at	1
				words for medic Cic and .		İ
	ENVIRONMENT	ORTABLE/HOMELIKE	F 252	HILLTVICWable regidence	ssed the]
}	- (Altainield)					ł
/7	The facility must provi	do o one				i
9	omfortable and home	de a safe, clean, elike environment, allowing				
ļ ti	he resident to use his	or her personal belongings				
τ	the extent possible.	Personal belongings		meals will be care planned acc 2. Unless it causes distress or bel	ordingly.	
		i		101 1001UCHES Who cannot	1	
+	his REOLUBELLE			Protectiones, a trial to be a trial	_	
(b)	A: A CERTAINENT	is not met as evidenced				
[]	ased on observation		j			
fa	iled to provide a homining in 2 of the 3 dinir	elike environmentality				
aii	ning in 2 of the 3 dinir	19 rooms observed	- 1			
ĴТЬ	e findissa (4236, VEQ.	- 1	families who all	ree j	
	e findings included:	·			heir	
∫ Ob	servation on Alalas	24 44.00	- 1	this is found to be appropriate.	om if	
floo	or dining room, revealed in wheelchairs or	at 11:30 AM, in the 3rd			viore	
f Sea	ted in wheelshain -	ov / residents were				
alo	ng the wall, with an o	reclining chairs, in a line ver bed table placed in	1			
Cor	nt of them, waiting for	their lunch trave	-			
rooi	ntinued observation, in revealed no tables.	n the 3rd floor dining	1	regarding those residents eating meals in the Family Room on the		
ĺ		·	1			
Obs	ervation on 6/9/15, at	6:20 pp.]			
floor	dining room revealed	d a total of 8 residents in		removed on the 3rd and 4th floors	to	
ine (dining area. Three rea	d a total of 8 residents in sidents were seated at a	İ			
Sing.	le lable in their wheel	chairs and 5 residents	- 1	homelike environment to include for both dining and activities.	tables	
Dia~	ed in front of "	chairs and 5 residents rs with an over bed table	4,	The DON administrations.	:	
table	with them with	rs with an over bed table th their meal tray on the] .			
	•	, === ===]			
	_	1	1			
-2567(02-99	9) Previous Versions Obsolete		- 1			
	10-0KW C020K(0	Event ID: P22U11		with Plan, Do. Study, Act Cycle w		

JUL-27-2015 08:00 DEPARTMENT OF HEALTH AND HUMAN SERVICES LAKESHORE FERNBROOK

CENTERS FOR MEDICARE & MEDICAID SERVICES P.005 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED 44A114 NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 06/10/2015 LAKESHORE HEARTLAND 3025 FERNBROOK LANE NASHVILLE, TN 37214 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION TAG DEFICIENCY) F 252! Continued From page 3 Observation on 6/9/15, at 5:46 PM, in the 3rd F 252 floor dining room revealed 8 residents seated in wheelchairs with an over bed table placed in front of them awaiting evening meal tray. Interview with Certified Nursing Technician (CNT) #1, on 6/8/15, at 11:40 AM, in the third floor dining room revealed, "They use to have tables in this area, but they took them out about 3 or 4 months ago...I don't know why." Interview with Certified Nurse Technician (CNT) #2, on 6/9/15, at 5:30 PM, revealed "some of the [over bed] tables come out of their rooms, but we keep some in there [dining room] for those that normally eat in there." Interview with the Administrator on 6/10/15, at 7:42 AM, in the Director of Nursing's office, confirmed over bed tables were being utilized in the 3rd and 4th floor dining rooms in place of F 278 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED F 278 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of

that portion of the assessment.

UEPAKTIMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

P.006 FINITED, 00/24/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES			FOR	RM APPROVI
AND PLAN	OF CORRECTION	(X1) PROVIDERSUBBLIEBIOLIS	001 M	ILTIPLE CONSTRUCTION	OMB N	O. 0938-03
		IDENTIFICATION NUMBER:	A. BUIL	DING	(X3) D	ATE SURVEY
					C	OMPLETED
NAME OF	PROVIDER OR SUPPLIER	44A114	B. WING	3	- 1	
		· · · · · · · · · · · · · · · · · · ·		STREET ADDRESS, CITY, STATE, ZIP CODE		6/10/2015
	ORE HEARTLAND		1	3025 FERNBROOK LANE		
(X4) ID	SUMMARY STAT	TEAST AND A STATE OF THE STATE		NASHVILLE, TN 37214		
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			TAG		PRIATE	COMPLETIO.
F 278	Continued From pag		 	DEFICIENCY		
-	Sourced Light bag	e 4	F2	78 1. On 06/22/15, Resident #12 was		07/30/15
j	Under Madicara	B# 11	· -	1. On 06/22/15, Resident #12 was		V//30/13
ļ	Willfully and knowing	Medicaid, an individual who		Leassessed on a quarterly Minimum	ım	1
j.	faise statement in a	y cerumes a material and		Data Set (ML)S) to correct the da	ta	1
				l curry crior.		1
	\$1,000 for each asser	ssment; or an individual who		1 In a state of the state of th	ition]
1	Milfully and knowingly	causes another individual		TOTAL COURT TO THE STATE OF THE		}
Į t	o certify a material ar	reauses another individual and false statement in a		assessments within the last 90 day	's for	ĺ
				data entry errors to section G0400 Two other assessments were found	١.	1
1	enalty of not more the	an \$5,000 for each		be miscoded and on 06/25/15 new	d to	<i>[</i>
1°	issessment.				·	
lo	linical disacro-			10. DCBming 06/24/15 the Tite	ĺ	
ก	linical disagreement naterial and false state	does not constitute a		Limichment Technisism - 1		
}	jeja esiai bito laise siji	ement.				
1_						J
į Ti	his REQUIREMENT	is not met as evidenced				- 1
by	<i>f</i> .	To not met as evidenced		The street of the Mile Aller Aller	Drior	ŀ
20	ased on medical reco	ord review, observation,		to completion of the MDS.	F	i
28	ed interview the facility sess the functional st	failed to accurately		4. The Director of Nurses (DON), or designed will be a few points.	1	ı
25	residents reviewed.	railed to accurately attus of 1 resident (#12) of		designee, will review each G0400 section prior to clearly at	- 1	- 1
		(12 / Ci	ļ	section prior to closing the MDS for days. If no errors are noted, the rev	90	1
Ϊħ	e findings included:	j	ł		icws	1
1			1		- 1	
Me	dical record review re	evealed Resident #12 was	1		ļ	- 1
adr	nitted to the facility or	evealed Resident #12 was 1 9/4/14, with diagnoses	-	TO THE DULLY ACT TO A TO A		
Oet	uding Chronic Pain, (eoarthritis, Dysphani	onstination General		TOMORIUM MINITO MAKE A		ĵ
Isch	eoarminis, Dysphagia	onstipation, General History of Transient	ſ	will be taken to the court	{	1
1.50	nemic Attacks, and In	somnia.		Assurance Committee.		
Med	lical record review of	<u></u>	j		ĺ	•
Data	Set (MDS) dated 2/	the quarterly Minimum	[- 1
impa	airment of the upper of	14/15, revealed no	1		1	
1	or or mic appeal	or lower extremities.	-]	[
Med	ical record review of a	the quarterly MDS dated	j			1
5/10 <i>,</i>	/15 revealed the resid	ne quarterly MDS dated lent had impairment of]		1	- 1
I the u	ipper and lower extre	mities myairment of				- 1
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\$-25 6 7(02-9)	Previous Versions Obsolete				- 1	- 1
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JUL-27-2015 08:01 LAKESHORE FERNBROOK CENTERS FOR MEDICARE & MEDICAID SERVICES

P.007 PRINTED: 06/24/2015

AND PLAN	NT OF DEFICIENCIES	(XI) PROVED SERVICES			FO	RM APPRO
1	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION	OMB	NO. 0938-0
		A SAMOREC	A. BUILD	DING	(X3)	DATE SURVEY
NAME OF		44A114	- 1			COMPLETED
I NAME OF	PROVIDER OR SUPPLIER	***************************************	B. WING		1.	
LAKESH	IORE HEARTLAND			STREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
		•	- 1	**** TERREROOK LANE		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES		NASHVILLE, TN 37214		
TAG	REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID ID	PROVIDED S DI LILI		
		DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE ACCOUNT	ION LDR⊨	(X5) COMPLETI
 				CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
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	UDServation of the -		F 27	8		
1:	AM, with Licensed P	ractical Nurse (LPN) #5 in	1	1		1
	have any a-	ractical Nurse (LPN) #5 in evealed the resident did not	1	1		1
1 6	extremities 1 may 40	es of the upper or lower	1			
∫ d	extremities, LPN #5; condition had not obe	stated the resident's		1		1
fi	unctions,	stated the resident's anged regarding extremity	1	1		
- 1				1		j
l in	nterview with the Dire	ector of Nursing (DON) on		1		1
0	710/15, at 8:50 AM, I	ector of Nursing (DON) on the conference room,			1	
in	of introder "The MDS	the conference room, Coordinator had entered				
1 11	ne MDS is taken	The MID OF MAY 2016		·	j	
1 87	IV Tiliomal -	THE TOTAL PROPERTY OF THE PROP				
F 312148	(3 25/a)/a) a	T " " " CAL EXITEDITIAS "	•			
SS≃D∤DE	EPENDENT RESIDE	INTS	F 312	1. A skin sevanna	- 1	
				A skin assessment for resident #61 completed for three described.	was	07/30/15
dai	esident who is unabl	le to carry out activities of	[completed for three days (06/11/15 6/13/15) with no skin concerns note on 06/24/15. An audit of the concerns note	i -	~112011J
ma	intain good many	le to carry out activities of necessary services to	1	On 06/24/15, an audit of all residen	ed.	
and	d oral hygiene.	necessary services to grooming, and personal	1	nceding assistance for activities of	its	
			1			
1		1	1	staff and five residents requiring a b	ed	j
Thin	Draw-	i	1.	2. On 06/24/15 :	ĺ	- 1
bv:	REQUIREMENT is	not met as evidenced	1			- 1
¦ ¤as	9d on facility		1		· [- 1
revie	W. Observation and	eview, medical record interview, the facility had	1 2	residents who use a bedpan.	п [- 1
i iali60	I to provide access	"" " Tiesy, the facility had I	-	· WILLIAM TO TIVE	- 1	- 1
COUL	nence care for 4 was	ident (#84)			,]	1
resid	ents reviewed.	95 (#G1) Of 25	j		au	- 1
The 6	india			Techniciane' biogles in	- 1	{
1100	indings included:	1	1			
Revie	W of the facilities		1	remove me promptly from the bed par		ļ
Offeri	w of the facility's pol- ng/Removing, revise led " Do not allow	cy, Bedpan/Urinal,		Please alert the charge nurse if 1	L	1
reveal	ed " Do make!!	2 October 2010.	1		.	1
bedpa	in for extended perio	ds . *	1		,]	İ
			4.	THE PRODUCTION AND ALEXANDE]
~	Previous Versions Obsolete			The Director of Nurses, or designec, will review with each care plan review	Ĭ	1
		Event ID: P22U11	Facility	and proplems well a care plan review	1	- 1

JUL-27-2015 08:01 DEPARTMENT OF HEALTH CENTERS FOR MEDICAGE	LAKESHORE AND HUMAN SERV	
CENTERS FOR MEDICARE	& MEDICAID SERV	ICES

NBROOK P.008 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 44A114 B. WING NAME OF PROVIDER OR SUPPLIER 06/10/2015 STREET ADDRESS, CITY, STATE, ZIP CODE LAKESHORE HEARTLAND 3025 FERNBROOK LANE NASHVILLE, TN 37214 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR USC IDENTIFYING INFORMATION) TAG PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 312 | Continued From page 6 F 312 Medical record review revealed Resident #61 was admitted to the facility on 11/20/13, with diagnoses including status post open reduction, internal fixation (ORIF) right hip, joint pain, general osteoarthroses, hypertension, and depressive disorder. Medical record review on 6/8/15, of the Quarterly Minimum Data Set dated 5/15/15, revealed the resident was totally dependent on staff for bed mobility, transfer and toileting needs. Review of the resident's care plan with a goal date of 8/28/15, revealed " ... I am incontinent of bowel and bladder. I use a bedpan, total assist with toileting and Peri care ..." Interview with the Resident on 6/8/15, at 2:56 PM, in the resident's room, confirmed on 6/7/15, the resident had pushed the call light at 8:50 PM and was placed on the bedpan. Continued interview confirmed at 9:50 PM, she pushed her call light to get help to be removed from the bedpan. Continued interview confirmed at 11:15 PM, the resident had not been removed from the bedpan, and removed the bedpan herself. The resident stated she did not see any facility staff until "a tech[certified nurse technician] came in at ten minutes 'til four." Interview with the Director of Nursing (DON) on 6/10/15, at 3:37 PM, in the DON's office, confirmed "fifteen to twenty minutes was a reasonable length of time for being on the bedpan" and the facility had failed to provide

assistance to maintain continence care for Resident #61, and had not followed their policy. JUL-27-2015 08:02 LAKESHORE FERNBROOK CENTERS FOR MEDICARE & MEDICAID SERVICES

P.009 FINALED. 00/24/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			FOR	M APPROVE
O SOURCHON	IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
NAME OF PROVIDER OR SUPPLIER	44A114	8. WING_			AMI F#150
LAKESHORE HEARTLAND		1	STREET ADDRESS, CITY, STATE, ZIP CO	DE O	6/10/2015
(X4) ID SUMMARY STA PREFIX (EACH DEFICIENCY TAG REGULATORY OR LS	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AE		(X5) COMPLETION DATE
(2) Store, prepare, dis under sanitary condition to the condition of the c	SCURE, SERVE - SANITARY sources approved or ry by Federal, State or local stribute and serve food ons is not met as evidenced stribute and serve food ons is not met as evidenced stribute and serve food ons is not met as evidenced stribute and serve and to maintain a properly maintaining one and by failure to sanitize ervice. icy Purchasing, no date, revealed stored to divil be stored in areas ation by condensation, by Handwashing Policy, se: To prevent the disease After touching		#1 1. On 06/08/15, dictary staff clearing build-up and debris from the walk-in freezer, covered the foam insulation and destroyed affected food. 2. The walk-in freezer was place routine cleaning schedule. 3. The freezer will be checked da any ice accumulation which with removed if build-up occurs. Distaff will be in-serviced quarter proper cleaning of the walk-in; by the Registered Dictician (RI Certified Dietary Manager (CD pipes in question were wrapped by the Director of Environment. Services on 06/18/15	aned the he floor of he black the don a lily for lil be ictary ly on freezer (b) and/or (c). The in metal al eck the first the ly for loot andy,	07/30/15

JUL-27-2015 08:02 LAKESHORE FERNBROOK DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

P.010 FORM APPROVED

STAT	EMENT OF DEFICIENCIES	E & MEDICAID SERVICES				FO	EM ADDDONA	
AND	PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIED/ALL		li Tu	O E POINTEN	FORM APPROVED OMB NO. 0938-039		
		IDENTIFICATION NUMBER	A. BUIL	יייי יייי	PLE CONSTRUCTION	(X3) DATE SURVE		
		}	1.00%	-11 W	3	0	OMPLETED	
NAM	E OF PROVIDER OR SUPPLIER	44A114	B. WING	3		1		
J		•		1	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	<u>6/10/2</u> 015	
LAF	(ESHORE HEARTLAND			1 :	3025 FERNBROOK LANE			
(X4) ID SUMMARY STO			1	NASHVILLE, TN 37214			
PRE	FIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ΙĐ	_	PROVIDER'S PLAN OF CORRECTM			
7/4	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF		I COUNT CLIPPED TRUE APPRAISANCE.		(X5) COMPLETION	
		·	٠٠٠٠		CROSS-REFERENCED TO THE APPROI	RIATE	DATE	
F:	371 Continued From no				DEFICIENCY)		İ	
• •	LANGUAGO LIONI DS	ge 8	F3	74			27.02.0	
	debns in the left cor	ner and around the edges o	e 13	′ 4			07/30/15	
	Strawberry on the	the racks, a 4 ounce (oz)	'	ı	I. On 06/09/15, the Certified Dietary	,	1	
			4		TATALIBUCT [CDM] conducted a	_]	
	cooler. Continued of	perioake on the floor of the		- 1	THE HI-SCIVICE With the ANAL (=	estion	}	
			1	- [*YAW WILK DINNEY BARA was ali (1	
				- 1	 On 06/10/15, the CDM conducted service for dietary staff members 	an in-]	
	rolls with black debri	s from the insulation in the	1	ĺ	regarding proper hand washing.		! !	
	Continued of box wit	h 8 loaves of garlic bread.		1.	". VII 00/30/15, the Registered Dines	·	ļ <u>}</u>	
	ice build up and	on revealed the 3 boxes had	ļ		(AL) COMMUNICATION STRATES IN A	i	1 1	
	ned politically stud Mete	on revealed the 3 boxes had available for resident use.	İ	- [Manning to received objects and a		1	
	Interview with the Cal	ola Arau-	1	-	TILLA BANASH II HOUBIIGUVYY	· · · · · · · · · · · · · · · · · · ·	'	
	in the kitchen, confirm	ok, on 6/8/15, at 10:26 AM, ned the facility falled to			Continue monthly times these manual	18	1	
	maintain cleanliness	ted the recently talled to		1,	and right quarterly	~	•	
	food items, in the wall	K-in freezer	ĺ	ן י				
				1	cooks' hand washing techniques we	ekly	1	
	AM in the kills	Cook on 6/8/15, at 11:15			for four weeks then monthly for the months and discontinue if complian			
	hands took hos early	ealed the Cook with gloved	>				1	
	food warmer removes	versied the Cook with gloved wiped her face, opened the	.	1	***** * **** **** * * * * * * * * * *	ns	j	
	returned to the travilla-	t down of pureed food,				. DC	1	
	hands, and continued	o serve food. Continued		1	Assurance Committee.	- 1	i i	
	observation at 11:23 A	M, revealed the Cook with	[- 1	[
	gloved hands took her opened the food warm.	abion wined the face					-	
	opened the food warmed	or, removed 2 bowle of	'			ì	1	
	pureed food, changed i	the gloves, without						
	washing the hands, and food.	continued to serve the	ļ			- 1	j	
		ĺ	ł			1	J	
1	Interview with the Cook in the kitchen, confirmed	On RIGHT				1	1	
į	in the kitchen, confirmed	the facility falls at]	ſ	
			1			}	1	
أددو]			1	1	
441	INLECTED BY CO.	NTROL PREVENIT				ĺ	ł	
.o=E	SPREAD, LINENS		F 441			ļ	ł	
	The facility many and and	·]	- 1			- }	1	
- 1	The facility must establis	in and maintain an	j				!	
			l l			- 1	1	

JUL-27-2015 08:03 LAKESHORE FERNBROOK CENTERS FOR MEDICARE & MEDICAID SERVICES

P.011 PRINTED: 06/24/2015 FORM APPROVED

TATEME	VT OF DEFICIENCIES	AND SERVICES			F	ORM APPROVE
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML	ALTIPLE CONSTRUCTION	OMB	NO. 0938-039
		A HOMOEK	A. BUIL	DING	(X3	DATE SURVEY COMPLETED
VAME OF	PROVIDER OR SUPPLIES	44A114	B. WING	 -		COMPLETED
	ORE HEARTLAND	·	·	STREET ADDRESS, CITY, STATE, ZIP CO		06/10/2015
	OVE HEAKTITAND			3025 FERNBROOK LANE	DE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		NASHVILLE, TN 37214		
PREFIX TAG	REGULATORS	Y MUST BE PRECEDED BY FULL	ID.	PROVIDER'S SLAN OF COM		
		INFORMATION)	PREFI TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)		(X6) COMPLETION DATE
F 441	Continued From pa	nge 9		#1		
	imection Control by	rama a d a	F 4	41 1. Observations for hand washin	no durina	07/30/15
ĺ	safe, sanitary and c	comfortable environment and				0.750/13
į	to help prevent the	development and transmission				1
Ì	of disease and infec	tion.		- VMV VII ODG IDSTDIANAN AN AL.	- 1	j
1				I The state of the	s needed	
}	(a) Infection Control	Program				1.
T I	THE ICUMIN MINES AND				ae outside	
- 17	Program under whic	h it -				1 1
	n the facility;	trois, and prevents infections				1 1
- 16	2) Decides what and					- -
8	hould be applied to	an individual resident; and		signage ("Please remember to hands between each resident	cleansc	
10	3) Maintains a rece-	The mount of resident; and		encounter,") was posted on 06/		1 1
ja	ctions related to infe	ections and corrective	•			1 1
1		-45.0,		- work wild longer ve Je-1		1 1
) Preventing Spread) When the Information	of Infection				
	When the Infection	n Control Program				1 1
q	etermines that a resi	dent needs isolation to				1
j pi	event the spread of	dent needs isolation to infection, the facility must		**************************************		1 1
13	plate the resident	"-" The recently must				1 1
(2	I ne tacility must pr	rohibit employees with a	- 1			1 1
fre	m disease	onibit employees with a or infected skin lesions	ĺ		itaken	
din	ect contact will	or infected skin lesions in residents or their food, if	-			
- ! (3)	The facility must -	t ala disease.	1		hirina	-07/30/15
hai	ids after each disease	mit the disease. Quire staff to wash their	- 1	medication administration were s	tarted	1
hạr	nd washing is indian	resident contact for which	ĺ	on 06/11/15 by the administrative nursing staff	;	1
pro	fessional practice.	ed by accepted	2	One on one inc.	1	1
- 1			- 1	One on one instruction and/or reti	am	J
(c)	Linens	ł		demonstration was provided as ne during the observations.	eded	1
Per	sonnel must handle, sport linens so as to	Store program	3	Hand foam was added to the 4th fi	- 1	
uran ind-	sport linens so as to	prevent the spread of	- 1			ſ
me	ction.	P stantale spread of	[. 1	1
ļ			١.)am	ĺ
1.	• •	1	4.	"" MAGNOF OF BURGAS IN. 11.	l l	1
This	REQUIRE			TABLE OF ALLE		
bv:	. ZAVIKEMENT IS	not met as evidenced		TYPE OF A MICHIGATION BRADE S		ſ
Bas	ed on rovious see		1		lu fo-	į
567(00 0	A ALLIENIEM OLISCIII	ity policy, observation	- 1			I
	9) Previous Versions Obsolet	Event ID: PZ2U11	 -L_	_ overprisett. II non-compliant a Bas	ot [1
		\ →- Aut (B*L5701)	Facility	In Allac Analysis with Dies Lie		i

JUL-27-2015 08:03 LAKESHORE FERNBROOK CENTERS FOR MEDICARE & MEDICAID SERVICES

P.012 PKINTED: U6/24/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	Taxa SERVICES			FOR	MAPPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION NG	(X3) D/	O. 0938-039 ATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	44A114	B. WING			
LAKESH	ORE HEARTLAND		1	STREET ADDRESS, CITY, STATE, ZIP CODE 3025 FERNBROOK LANE	<u> </u>	5/10/2015
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPRO	~ ~~	(XS) COMPLETION DATE
First Confidence of the constant of the consta	cross contamination times for 5 of 12 residents follow infection control handwashing during a 1 resident of 4 resident are resident or 2 of 2 residents, on 2 of 2 residents, on 2 of 2 residents, on 2 of 2 residents, on 2 of 2 residents, on 2 of 2 residents, on 2 of 2 residents, on 2 of 2 residents, on 2 of 2 residents, revised 4/20 isibly soiled, use an abbuilt before and after residents" Abservation on 6/8/15, or dining room revealed to assist her servation revealed Continued observation and without disinfecting resident without disinferesident without disinferesidents without disinferesidents without disinferesidents without disinferesidents without disinferesidents without disinferesident, began feeding in wiped a third resident revealed on wiped a third resident revealed or revea	cility failed to follow infection minimize the potential for between residents at meal dents observed, failed to ol guidelines for medication administration for ents observed, and failed to lifts were cleaned between esident units observed. coolicy, Handwashing/Hand 10, "if hands are not alcohol-based hand direct contact with at 12:03 PM, on the fourth aled Certified Nursing eeding a male resident, revealed CNT #3 stood up the hands, walked to a 1 at a different table, patted he back of the chair, and with eating. Continued NT #3 walked away from I resumed feeding the isinfecting the hands. at 12:07 PM through 12:09 continued to assist both ecting the hands.	F 44	DEFICIENCY)	ion ment, ne k for tor nue t will and	07/30/15

JUL-27-2015 08:04 LAKESHORE FERNBROOK DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

P.013
PRINTED: 00/24/2015
FORM APPROVED
OMB NO. 0938 0301

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(140) 444		OMB NO	<u>OMB NO. 0938-039</u>		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED		
NAME OF	PROVIDER OR SUPPLIER	44A114	B. WING			/10/2015		
	ORE HEARTLAND			STREET ADDRESS, CITY, STATE, Z 3025 FERNBROOK LANE NASHVILLE, TN 37214	IP CODE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	 <u></u> -1					
PREFIX TAG	TENON OBFICIENCY MUST BE PRECEDED BY BILL		PREFI		'ION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE		
F 441	Continued From page sanitizing the hands	ge 11 ,	F 4	41				
	i vie unility toom, can	#3 on 6/9/15, at 5:53 PM, in firmed CNT #3 failed to wash after touching the third			į			
	September 2012, rev	's policy, Infection Control rsing Procedures, revised realed, "Employees must ter handling items potentially pod"						
	Observation on 6/9/1: Licensed Practical Nu medications in the ha observation revealed	5, at 7:41 AM, revealed urse (LPN) #2 administering ilway. Continued the LPN disposed of a pill in		·				
, ,	······································	on 6/9/15, at 7:41 AM, in the hands were not the dirty sharps container.	•					
E it	conduit-cate equip	nt-Care Items and ctober 2009, revealed ment, including reusable						
O a: e: th	bservation on 6/10/1: nd 4th floors revealed ach floor with heavy o	5, at 1:32 PM, on the 3rd 4 resident care lifts on trey debris at the front of	ı					
In Si	terview with the Hous pervisor on 6/10/15	ekeeping/Laundry et 2:30 PM, in the looby.						

JUL-27-2015 08:04 LAKESHORE FERNBROOK DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

P.014 PRINTED: 06/24/2015 FORM APPROVED

STATEME	いし ひと ひににいいにんかんさ	E OF INFEDICATO SERVICES			FOR	M APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		O. 0938-039
		IDENTIFICATION NUMBER:	A. BUILDI	NG	(X3) D	ATE SURVEY
		44A114	B. WING_	······································	ı	
NAME Q	PROVIDER OR SUPPLIER		1		06	3/10/2015
I VKEG	HORE HEARTLAND		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
□ -1(□ Q)	HOVE HEAK! LAND			3025 FERNBROOK LANE		
(X4) ID	SINDAMONOS			NASHVILLE, TN 37214		
PREFIX	1 AAAD DELICIEMES	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID.	PROVIDER'S PLAN OF CORRECTI	ON .	 -
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O DE	COMPLETION CATE
F 441	Continued From page	go 12				
	Confirmed the resid	8e 12	F 44	1 1. On 06/25/15, the activity director		07/30/15
	Appropriate (45 tesion	ent care lifts on the 2 resident		The state of the s		
	I write were dirty, and	COnfirmed the feelih		conducted an audit of preferences	for	1
	LANGUAGE OF LESIGENT	care lifts were cleaned		residents who eat in the dining are	as on	
E 404	Privicum residents			mu 3 and 4" floors regarding ear	ina at	1
1° 464	483.70(g) REQUIRE	MENTS FOR DINING &	F 464	a dining table or eating on over he	d	1
SS=E	ACTIVITY ROOMS		F 4Q4	" undies for meals. Six of the		
	1 99r A			interviewable residents expressed	the	j
	The facility must provide one or more rooms			Preference of cating at a table and	turo	
ĺ	designated for reside	ent dining and activities.		PARTOSSED THE DISTRICTORS to Aut on	A '	
i				bed wotes of at a table. Those resi	donta	
	These rooms must b	e well lighted; be well		I will encose to eat on over hed table	on fa-	
	TYTHICKEN, WITH HANGI	MOVING Assessing to the second		means will be care planned accords	m ~ T	
Ì	4446M MINISTER	* 200 Baye 6.46.1		1 4 CHUSES IL CHUSES DISTIESS OF helional	Ore	ĺ
	to accommodate all a	activities.		101 residents who cannot voice	1	
- 1				preferences, a trial, to begin the no	أعمامه	,
				07/06/15, will be conducted regard	10 25	ľ
j	This REQUIREMENT	is not met as evidenced		those residents eating their meals in	ing	
I .				Family Room on the first floor who	n the	
- 1	Based on observation	n and interview the facility		there are tables available. The Dire	re [
				of Nurses (DON) spoke with three	ctor	ľ
- 13	3 dining rooms obser	ved.	i	families who all preferred that their	ŀ	į
- 1		•	í	loved ones eat in the Family Room	.	
	The findings included:	: 1	i			- 1
			ł	3. Unless it causes distress or behavior	}	
19	Observation on 6/8/15	, at 11:30 AM, in the 3rd		residents who require extensive or r	75,	i
, .	TO THE PERSON OF	19104 7 hazīda(1	assistance in diving with	oax	ĺ
	ARCON III AMIESMILLIMIES	Of fooling was a little of the control of the contr	ĺ	assistance in dining will participate	ina [ŀ
			1	trial, to begin the week of 07/06/15,		j
1	Tried, Bigin Wannin III	15 TDOIT MAGALAGA 6.		regarding those residents eating their	r	
s	erved. Continued obs	ervation revealed there	1	meals in the Family Room on the fir	st	J
พ	vere no dining tables i	D the digina seem	1	floor where there are tables available).	Ī
		are cital & toom.		By 07/03/15, nursing stations will be	,	
10	bservation on 6/9/15	at 5:30 PM, in the 4th		removed on the 3rd and 4th floors to	- 1	
1 ***	YY YEMBU TOOM, NAVA	2/2/1 2 total as 0 1 - 1	Ì	allow for additional space and a mor	¢	- 1
			}	notherize environment to include the	les	
re	Vealed 1 dining table	and 3 residents seated in		for both dining and activities.		1
w	heelchairs around the	table Continued	"	The DON, administrator or designee,	, [,
ol	bservation revealed 5	other resident		will observe these dining expansioned	. !	į
} -		outer residents were	1	weekly times four weeks, then month	der i	ļ
MS 2507	03 003 9			runes intec months. If experiences as		ł
(I	02-99) Previous Versions Obsc	Nete Event IO: PZZU11	Capita	y ID-IN9ther D. a Poot Cause Analysis		

JUL-27-2015 08:05 LAKESHORE FERNBRO DEPARTMENT OF HEALTH AND HUMAN SERVICES LAKESHORE FERNBROOK CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

P.015 PRINTED: U6/24/2015 FORM APPROVED OMB NO. 0938-0391

	STATEMEN	T OF DEFICIENCIES	TOWN THE SERVICES				OMB N	VO. 0938-039
ļ	AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
i			44A114	B. WIN	3		1	
ı	NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	(<u>06/10/2015</u>
	LAKESH	IORE HEARTLAND			30	025 FERNBROOK LANE ASHVILLE, TN 37214		
ſ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1 10				
	PREFIX TAG	I CACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG	7X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	n ec	COMPLETION DATE
	F 464			F	164			
		seated in wheelchai placed in front of the the over bed table.	rs with an over bed table em with their meal placed on			·		
		wheelchairs with an	15, at 5:46 PM, in the 3rd vealed 8 residents seated in over bed table placed in front neir meal to be served.					
		lover bed tables con	ed Nurse Technician (CNT) O PM, revealed "some of the ne out of their rooms, but we dining room) for those that					
		confirmed over bed to	ministrator, on 6/10/15, at tor of Nursing (DON) office, ables were being utilized in dining rooms in place of	•				
			,					
	ļ							
							Í	
ł	M CMS-2587(02-99) Previous Versions Obs	alela Durat III					